CHILD SURVIVAL VII
CAMEROON SOCIAL MARKETING PROJECT

FINAL EVALUATION

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TABLE OF CONTENTS

Acronyms

A.I.D.	Agency for International Development
BHR/PVC	Bureau of Food and Humanitarian Assistance/Office of Private and Voluntary Cooperation
CPR	Contraceptive prevalence rate
CYP	Couple-years protection
DIP	Detailed implementation plan
DHS	Demographic and Health Survey
FY	Fiscal year
KAP	Knowledge, attitude and practice
MIS	Management information system
MOH	Ministry of Health
NGO	Non-governmental organization
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
PSI	Population Services International
PVO	Private voluntary organization
SCF	Save the Children Federation
STD	Sexually transmitted diseases
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

The Child Survival VII Cameroon Social Marketing Project, implemented by Population Services International (PSI), began in mid-September 1991 with a total budget of $667,700 for three years. The project covered two child survival interventions: diarrhea1 disease management and family planning. The project's main activities were social marketing of condoms, oral contraceptives and oral rehydration salts (ORS), which included the promotion and distribution of these three commodities through private sector networks, and the training involved. The project covered the ten most populated urban centers in Cameroon, targeting 515,000 women of reproductive age and 397,000 children under five years of age.

The project accompiished its target in the distribution of condoms (16.8 million were distributed in the three year period), and thus one of its two objectives to increase the contraceptive prevalence rate by 3%. The project however, did not achieve its targets in the distribution of oral rehydration salts (ORS) and oral contraceptives, and thus its other objective to increase the use of oral rehydration therapy.

The implementation of the social marketing of ORS and oral contraceptives were impeded by lengthy delays in obtaining a country agreement between PSI and the Ministry of Health (MOH), regulatory approval for the sale of ORS and the oral contraceptive (Norminest) and a court seal of the warehouse in which the commodities arc stored imposed by former sub-contractor.

The Child Survival Project, building on the success of the condom social marketing program and the existing infrastructure had a good potential for achieving the objectives as defined. Unfortunately, circumstances beyond its control prevented the project from demonstrating the effectiveness of the social marketing approach to increasc the use of ORS and oral contraceptives.

The lessons learned in the implementation of the Cameroon Social Marketing Project for Child Survival are:

i) Although social marketing involves mainly the private sector, a good working relationship needs to be established with the MOH, and its involvement and formal commitment needs to be obtained from the project design stage.

ii) The implementing agency needs to establish a presence in the administrative capital, conducive to a close working relationship with the Ministry of Health.

iii) In order to provide protection from potential litigation, the Ministry of Health needs to be formally involved in contractual agreements as a partner.

iv) Granting of government regulatory approval for pharrnaccutical products or its waiver should be included in the USAID bilateral agreement where such products are funded bilaterally.

v) A regional strategy using sales agents based in each province to assist the local wholesalers in marketing and promotion is successful in increasing sales.

vi) Care should be taken in the selection of distributors and a monopoly distributor should be avoided.

vii) NGOs which have community health projects may be associated to reach rural areas which are not well served by the commercial distribution network.

viii) Small-scale baseline research should be carried out before a promotional campaign or activity, in order to provide a basis for planning, monitoring and evaluation of the activity.

INTRODUCTION

In September 1991, Population Services International (PSI) was provided funding of $500,000 for the Child Survival VII Cameroon Social Marketing Project by A.1.D through the Bureau of Food ad Humanitarian Assistancc/Officc of Private and Voluntary Cooperation (BHR/PVC). The project had a total budget of $667,700 for three years. The project ended in September 1994.

The project covered two child survival interventions: diarrhea1 disease management and family planning. The project's main activities were social marketing of condoms, oral contraceptives and oral rehydration salts (ORS), which included the promotion and distribution of these three commodities through private sector networks, and the training involved. The project covered the ten most populated urban centers in Cameroon, targeting 515,000 women of reproductive age and 397,000 children under five years of age.

Funding from the Child Survival Project VII enabled PSI to continue and expand the condom social marketing activity which it started in 1989, as well as provided support to begin social marketing of ORS and oral contraceptives. This project was developed with the rationale that it would be cost-effective to use the established social marketing infrastructure to promote other contraceptives and products such as ORS, making thcsc products more widely available and affordable for the population most in need. Under the project, a new condom brand was marketed, positioned as a condom for women and family planning. Funding from two other AID projects, AIDSTECH/AIDSCAP ($697,000 for the period Ott 89 to Sept 95) and SEATS ($383,000 for the period Aug 92 -May 94) were pooled with Child Survival Project funding to support condoms and oral contraceptive social marketing activities. Condom and oral contraceptive commodities were funded under the USAID bilateral population project.

Given the nature of social marketing, this project does not fit in the mold of the typical Child Survival Project. The final evaluation is therefore conducted according to BHR/PVC guidelines where they can be applied. The guidelines are found in Appendix 1.

I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Proiect Accomplishments

Al. The **goal** of the project is to contribute an essential component to the current Ministry of Health (MOH) strategy for improving child survival in Cameroon through the social marketing of a packaged ORS and of contraceptives for child spacing.

The objectives of the project, as stated in the Project Proposal are as follows:

1) to increase the proportion of children under five years in the target population who are given oral rehydration therapy (ORT) during episodes of diarrhea from 16 to 35 percent by Year Three of the project; and
2) . to increase the proportion of contraceptive prevalence in the target population from 3 to 6 percent by Year Three of the project.

These objectives were not modified in the revised Detailed Implementation Plan (DIP) although the project baseline survey', conducted in December 1993, found much higher levels of ORT and contraceptive use than projected as starting points. In fact they were closer to or exceeded the expected levels at the end of the project. The survey found that 32% of children under five who suffered an episode of diarrhea in the two weeks preceding the survey were given ORS, and 12.3% of women interviewed in four cities had used a contraceptive in the past three months. The survey report did not provide the proportion of children given ORT (using ORS and/or home-made solutions).

A.2 A final evaluation was not conducted to measure project impact. While project accomplishments cannot be assessed in terms of the objectives, they can be assessed in terms of outputs. The levels of some of the outputs were changed in the DIP from those of the project proposal, although no explanation was given for the changes.

The following table shows the project's achievements in outputs or end of project status. The outputs for number of condoms, pills and ORS packets distributed are the revised levels from the DIP, while the rest of the outputs are as listed in the project proposal as they were not described in the DIP.

Output Indicators	Targets	Achieved over LOP (10/91-9/94)
# Condoms distributed*	16.5 million	16.8 million
# Oral contraceptive cycles distributed*	380,000	6,240
# ORS packets distributed*	1,925,000	20,736
# brochures produced	50,000	1,045,000
# posters produced	20,000	35,000
# radio spots # airings	18 180	3 364
Value of point-of-purchase promotional materials**	$70,000	$45,000
# newspaper ads	18	6
# wholesalers trained	90 - 135	53
# retailers trained	180 - 225	108@

* Figures represent commodities sold to distributors and distributed as free samples. Samples represent 4% of total distributed.

** Includes t-shirts, stickers, banners, bags, fishbowls

@ Retailers trained were pharmacists

[1] Tchupo JP, Foyet L, Lybrook S, Gruber-Tapsoba T. Comportements, attitudes et pratiques des femmes en milieu urbain face à la diarrhée infantile et à la contraception. PSI Yaoundé; Janvier 1994.

In addition, one television advertisement was produced and broadcasted 36 times, a film for television on the prostitute theater group, two TV talk shows on condoms and social issues, 10 radio broadcasts on a promotional 'scratch and win' game, and 2,530,000 product inserts were produced.

The yearly targets and achievements for distribution of condoms are as follows:

	Target	Achieved
Year 1	4.5 million	4.82 million
Year 2	5.5 million	5.73 million
Year 3	6.5 million	6.24 million

Of the total condoms distributed, 502,000 or 3% were of the *Promesse* brand. The detailed figures for sales and samples distributed of each brand by month can be found in Appendix 2.

In Year 3 the target would have been met and even exceeded by at least one million condoms if it were not for the seal of the warehouse in June 1994, resulting in stock outages until a new shipment was received in September 94. Monthly salts were averaging over 500,000 condoms during the first six months of 1994.

The yearly targets for ORS and oral contraceptive distribution were not achieved as these products were not launched until the last quarter of Year 3, and the marketing activities were interrupted three weeks after they began.

It can be seen from the level of outputs that the project has been unable to achieve Objective 1, but has achieved Objective 2 in increasing the contraceptive prevalence rate (CPR). This increase is primarily due to the increase in the use of condoms.

According to the DIP, the project should cover the ten most populated cities. In reality, the project covered the nine most populated cities (Loum dots not have a condom distributor) as well as eight other cities and towns including the provincial capitals. As condoms are distributed beyond the ten major cities described in the DIP, the population covered is actually greater than the figure of 515,450 women of reproductive age and 397,254 children under 5 years of age cited. The number of women of reproductive age residing in the area covered is estimated to be 811,311 and the number of children under 5 years to be 629,034 in 1994. (The list of cities with a condom wholesale distributor in the project area and their populations can be found in Appendix 3.) The quantity of condoms distributed by the program in FY 94 (October 93 to September 94) provided 41,589 couple-years of protection*, compared with 16,218 CYPs distributed in FY 91, representing a 260% increase. Using the number of women residing in the project area in the given year as the denominator and the number of CYPs provided in the year as nominator, the condom user rate in the project area can be shown to have increased from 2.3 % in FY 91 to 5.1% in FY 94, an increase of 2.8%, which matches the 3 % increase in the CPR projected in Objective 2. This corresponds to the condom user rate of 2.2% found in Yaoundé/Douala by the 1991 DHS, and 6.1% found by the project baseline survey of December 93 (the latter is probably a slight over-estimation of actual user rate due to the methodology used).

[2] 150 condoms provide a couple with 1 year of protection

The promotional activities conducted for condom marketing have been effective in increasing brand recognition for the ***Prudence*** condom marketed under the project. A study of the national media commissioned by PSI and conducted from May to December 93 found that 58% of persons interviewed in six major cities could remember the brand name of ***Prudence,*** 59% of whom retained the message of "prevention of AIDS and STDs". Only 7% could remember the other condom brand marketed under the project, ***Promesse*** which is a higher-priced condom sold mainly in pharmacies. Although the project's strategy was to market the *Promesse* condom aimed at women and emphasize its use for family planning rather than prevention of AIDS and STDs, only 8% could cite the messages on fidelity and keeping one's promise. This indicates that the marketing strategy for the ***Promesse*** condom is flawed and needs to be reviewed, and message development needs to be improved. The message on contraception was only cited by 1% of all the respondents.

The project was therefore successful in increasing the awareness of condoms and its use for the prevention of AIDS and STDs, but not for family planning. As HIV/AIDS prevention is now included as a child survival intervention, the project could be considered as having expanded to cover this intervention.

PSI is aware of the need to enhance the family planning message for the Promesse condom and has developed and produced a family planning brochure in collaboration with the Directorate of Family and Mental Health, which will be distributed when new condom stocks are available.

The planned and actual implementation schedules are shown in the table on the following pages. The recruitment of personnel, procurement of supplies and technical assistance activities were implemented according to or even ahead of schedule. The major delays were in the implementation of the health or management information system, initiation of service delivery in the ORT and family planning (oral contraceptives only) areas, and training related to these areas.

The performance of the social marketing program in the different provinces is rather uneven. The breakdown of condom sales figures by province show that sales are low in the predominantly Muslim Northern provinces and in the anglophone Southwest and Northwest Provinces (See Appendix 4). More market research is indicated in these regions to determine more effective distribution channels and marketing strategies for each region.

COUNTRY SCHEDULE OF ACTIVITIES

PVO: PSI

Country: CAMEROON

	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
1. Personnel in Position												
a. Project Manager	X *											
b. Technical Coordinator (Marketing)	*	X										
c. Health Information System Manager (Director of Research and Communications)	*	X										
d. Community/Village health workers												
e. Other Support		X										
2. Health Information System												
a. Baseline Survey												
- Design/preparation			X				*	*				
- Data collection and analysis			X						*			
- Dissemination and feedback to community and project management			X									
b. Consultants/contract to design HIS (Staff member)			X				*					
c. Develop and test HIS			X									
- Implementation			X									
- Development and feed back to community and project management			X									

X= Planned date of implementation
* = Actual date of implementation

COUNTRY PROJECT **SCHEDULE** OF ACTJVJTJES

PVO: PSI

Country: CAMEROON

	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
3. Training#												
a. Design				X							*	
b. Training of trainers				X							*	
c. Training sessions					X						*	
d. Evaluation of knowledge of skills							X					
4. Procurement of Supplies	*		X									
5. Service Delivery to be initiated												
a. Area 1												
- ORT			X								*	
- Immunization												
- Nutrition:												
Breastfeeding;												
Growth Monitoring/Promotion												
Vitamin A												
- ALRI/Pneumonia												
- Family Planning/Maternal Care			X								*	
- Other (HIV)	*											

X= Planned date of implementation

* = Actual date of implementation

Training for ORS and oral contraceptive marketing. Training in condom marketing was carried out before start of CS Project.

COUNTRY PROJECT SCHEDULE OF ACTIVITIES

PVO: PSI

Country: CAMEROON

	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
b. Area 2												
- Control of Diarrhea1 Diseases												
- Immunization												
- Nutrition:												
Breastfeeding												
Growth Monitoring/Promotion												
Vitamin A												
- ALRI/Pneumonia												
- Family Planning/Maternal Care												
- Other												
6. Technical Assistance												
a. HQ/HO/Regional office visits	*	X		X	*	X	*	X *		X	*	X
b. Local Consultants				*			*					
c. External technical assistance		X	X	*	X		X				X	
7. Progress Reports												
a. Annual project reviews				X				X				X
b. Annual reports				*	X				X			X
c. Mid-term evaluation							X		*			
d. Final evaluation#												X

X = Planned date of implementation

* = Actual date of implementation

-Completed in February 1995

A.3 The implementation of the social marketing of oral contraceptives and ORS was impeded by extensive delays in obtaining the country agreement, regulatory approval from the MOH and AID, and legal problems.

Country Agreement

The country agreement was first submitted in November 1991 but was not signed until June 1993, after numerous drafts and six submissions to the Minister of Health. In view of the long delays and in order to expedite the obtaining of the country agreement, the final agreement submitted covered only the social marketing of condoms. It was then amended nine months later, in March 1994 to include oral contraceptives and ORS. The MOH did not approve the initial draft of the country agreement presented because of the broad terms used to cover the products to be marketed. PSI had intended to use the term "health care products" rather than specific products so that other products could be added to the program later without having to go through the slow amendment process. Although these terms have been used in country agreements elsewhere, they were not acceptable to the Cameroon MOH and the strategy actually back-fired. There was also disagreement over the social marketing of the MSTOP kit for the treatment of sexually transmitted diseases (STDs) and the antibiotics to be included in it. The MSTOP activity was eventually dropped.

Government Regulatory Approval for *Biosel* (ORS) and *Novelle* (Oral Contraceptive)

PSI had assumed that the ORS and oral contraceptives to be marketed, being donated commodities, would be exempt from regulatory approval from the Directorate of Pharmacy, which is mandatory for all pharmaceuticals sold in the private sector in Cameroon. This proved to be not the case and the request for a waiver of the hefty registration fees from the Directorate of Pharmacy was also denied. The process of obtaining approval for these two products turned out to be extremely lengthy. The documentation for the oral contraceptive, Norminest Fe was first submitted in October 1992, and regulatory approval for both Norminest and the ORS (to be sold under the brand names of *Novelle* and *Biosel*) was finally granted in May 1994. Initially, approval could not be granted as PSI did not have a country agreement. The request was then rejected several times due to labelling, packaging, pricing and procedural reasons. PSI was required to provide proof of support from the two Directorates overseeing the marketing of the two products, as well as hire a pharmacist to oversee certain operations. PSI conformed to the demands of the regulatory commission and made the necessary modifications and supplied the necessary documentation after each review. The process could have been expedited if the Directorate of Pharmacy and the regulatory commission specified all of the requirements at one time, rather than raising a different issue at each review meeting.

With hindsight, these delays might have been avoided if a condition for granting regulatory approval for the social marketing products within a specified and reasonable period were included in the conditions precedent in the USAID bilateral agreement with the Government of Cameroon for the National Family Health Project.

MOH officials involved in the process of approving the country agreement and the sale of ***Biosef*** and *Novelle* are responsible for the delays, some of which seem to have been deliberately caused, indicating a lack of support for the project. The lack of support may be attributed in part to PSI's failure to prepare the groundwork adequately. MOH officials

were not sufficiently involved and informed from the project design stage and did not understand the concept of social marketing, so that much misunderstanding arose over the purpose of the project and the role of PSI. More activities to create awareness among key MOH officials needed to have been carried out during the design phase and their formal commitment to the project sought. Inadequate attention was given to developing the relationship with the MOH as the former PSI country representatives focused more in developing relationships with private sector partners.

The lack of presence of PSI in Yaounde compounded the difficulties in following-up the processes after they were launched. The PSI country office was initially located in Douala, the commercial capital which is 280 km from Yaounde, the administrative capital. Although frequent trips were made to Yaoundé by the PSI country representative, it was often difficult to obtain appointments and schedule meetings that suited the Ministry officials. The relationship between PSI and the MOH improved significantly after the arrival of the current representative and her move to Yaounde in December 1993, when constant contact and exposure could be made.

AID Approval for ORS Procurement

In September 1992, it was reported in Morocco that the locally manufactured ORS sold through the social marketing program implemented by PSI wcrc dcfcctivc and the ORS were subsequently withdrawn. As a result, PSI was required to provide testing of the ORS to be sold in Cameroon first by the manufacturer in Germany, then by an independent laboratory, and correlation of the test results. The expenses for independent testing and correlation of the test results were not budgeted for in the project. The process took a considerable amount of time, and approval for release of the product was finally granted in December 1993. Quality assurance is necessary in view of the potential dangers posed by faulty products, but the clearance process could have been expedited by the PVC Office, as there were lengthy delays in responses provided to PSI. Although this did not cause any additional delays to the launching of ORS as it was still awaiting MOH regulatory approval, the lengthy clearance process imposed an additional burden on PSI and project staff, who had to follow-up on obtaining the release.

Warehouse Seal and subsequent litigation

Three weeks after the launching of ***Biosef*** and *Novelle* began in June 1994, a former sub-contractor of PSI for warehousing, packaging and distribution, ***Groupe Sante'*** obtained a court order to impose a seal on the warehouse and a freeze on the PSI bank account in Douala, three months after being informed that PSI would not renew their contract. The warehouse seal interrupted all project activities. Condom distribution was able to resume after a new shipment arrived but ORS and oral contraceptive distribution has not been able to resume as all the stocks of commodities, packaging and promotional materials are in the warehouse. ***Groupe Sante'*** has accused PSI of breach of promise, although there has been no breach of contract between the two parties. As ***Groupe*** *Santé* is a sub-contractor and not a partner, the seal was imposed without legal grounds. After several adjournments of hearing of PSI's appeal to have the seal lifted and a "declaration of incompetency" by the presiding judge, PSI decided to file suit against ***Groupe*** *Santé*, in an attempt to obtain a rapid hearing in higher court and a lifting of the seal. Despite an order from the Minister of Health to ***Groupe*** *Santé* to have the seal lifted, the warehouse is still under seal at the time of the evaluation, and

Groupe Santé is employing delay tactics to delay judgement of the case. The MOH after some initial hesitation has now pledged its support to PSI. Although PSI and the Ministry of Health have tried to impress the Ministry of Justice with the urgency and important implications of the warchousc seal on the health program, the legal system has been unresponsive.

It appears that the ORS and oral contraceptive social marketing activity will have to await the resolution of the litigation. The high litigation costs have to be borne by PSI. Meanwhile, the press has become interested in the case, and three newspaper articles have been published one of which falsely accused PSI of marketing expired condoms. Fortunately for the program, the written press does not have a wide readership nor much credibility. The effect of the adverse publicity is not known.

In retrospect, PSI should have checked out ***Groupe Santt's*** record more thoroughly and obtained references from those who have had dealings with its director, Dr. Wandja, although he was introduced by the former Chief of the AIDS Control Unit, Dr. Kaptue. To avoid litigation problems of this nature, the MOH could have been associated as a co-signee in the sub-contract between PSI and other NGOs as suggested by the MOH legal counsel, although involving the government bureaucracy could lead to a certain amount of delay.

Other Implementation Issues

The detailed implementation plan (DIP) first submitted in June 1992 was found to be unacceptable by the PVC Office and PSI was requested to revise and resubmit it. After some negotiation, the PVC Office agreed to accept the DIP after revision to include supplemental baseline information. The revised DIP was submitted in June 1994. Comments on the DIP were returned in September 1994 after project funding had ended, rendering the whole exercise rather futile. Although some of the comments made by the technical review committees were not relevant to social marketing projects, others were pertinent. The DIP should have been revised to address some of the valid concerns of the review committee and followed, to make the exercise a useful one. The comments made by the review committee of the revised DIP, particularly those concerning monitoring and evaluation were most pertinent and would have been of benefit to the project if they had been provided in a timely fashion.

As the DIP was not revised according to findings of the baseline survey and experiences up to that point, it was not a realistic plan that could have been followed. The DIP also did not take into account the time required to prepare the launching of new products. Procurement, market research, development of training and marketing strategies and plans, and development of packaging and promotional materials, all need to be completed before a product can be launched. Even without the delays mentioned above, ***Biosef*** was ready for launching only in May 93 and ***Noveffe*** in September 93, towards the end of Year 2. The targets of 725,000 ORS packets and 180,000 cycles of oral contraceptives to be distributed in Years 1 and 2 were therefore not realistic.

One of the weaknesses in the implementation of the project lies in the Management Information System (MIS). The mid-term evaluation pointed out that the project's monitoring system is inadequate as it tracks only condom distribution and sales by wholesalers. There was no computerized inventory, tracking system for promotional

materials, nor system to consolidate and track information gathered by the baseline survey and various market research studies. Although the project proposal included a Health Information Specialist among the human resources required, this position was later changed to that of the Director of Research and Communications and the MIS component of the program has been rather neglected. This weakness is now being rectified as a staff member was appointed to be responsible for the MIS in September 1994, and is in the process of setting up a computerized MIS for inventory control, that can be reconciled with statistics on commodities and promotional materials distributed, as well as revenues. There is currently no accurate information on semi-wholesalers and retailers. The MIS should be used for more than just tracking commodity distribution and revenues, but should also be used as a tool to evaluate performance of wholesalers.

A request for waiving the baseline knowledge, attitude and practice (KAP) survey was made but not granted by the PVC Office, although data on contraceptive and ORS knowledge and use in the project area could be made available from the 1991 Demographic and Health Survey. The project staff considered obtaining the results disaggregated for the project area only (10 major cities) from the Census Directorate but discovered that the costs would be as high as conducting a survey. All these considerations led to some delay and the baseline survey was not conducted until December 1993. The DHS preliminary report was ready in June 1992, and the final report was published in December 1992.

The overall results of the two surveys are not comparable as different sampling methods were used. The baseline survey sample has a higher proportion of women between the ages of 20 and 34 as only women with children under the age of five were-interviewed. Women from four major cities were interviewed, the majority (73%) of whom were from Yaounde and Douala, whereas in the DHS, 53% of women from urban area were from Yaoundé and Douala, while 47% were from other urban areas defined as those with populations greater than 5000. The baseline survey questionnaire asked for contraccptivc use in the past three months and not current use. The rate of contraceptive use found thcrcfore would be higher among the baseline sample than the DHS. Nevertheless, when only Yaounde and Douala only are considered, the results found are quite close. The DHS found a contraceptive prevalence rate of 12.1% while the baseline survey found that 13.7% of women had used a modern contraceptive in the last three months. As for ORS use, the DHS found that 24% of children in Yaounde and Douala were given ORS during a diarrhea1 episode in the preceding two weeks, compared to 33% found in the baseline. These differences may be explained by the differences in methodology mentioned above and the time lapse between the two surveys.

It is questionable whether a baseline survey was necessary, as the 1991 DHS report provided all the information necessary on contraceptive and ORT KAP in the urban areas, as well as segregated for Yaoundé/Douala, and "other urban areas". Although the other urban areas included smaller towns than those covered by the project, the project in reality covered more than the ten major cities, and retailers come from the surrounding smaller cities and towns. Results from the DHS should have been used as baseline, and an evaluation survey should have been conducted instead, using a smaller sample with a similar distribution of certain characteristics.

As the baseline survey was not conducted until two years after the project began, the results no longer represent the situation at the start of the project. It therefore could not serve its

purpose as a baseline survey, and a final evaluation survey was not warranted as the interval between the two surveys would have been too short to demonstrate any significant changes. In addition, the launching of oral contraceptives and ORS on the market was interrupted just after it began, so that no mcasurablc results concerning ORS and pill USC could be expected.

Publicity campaigns conducted under the project such as the 'scratch and win' game for the ***Prudence*** condom in December 1992 were never evaluated due to the lack of funds. Such evaluations would have been useful in the development of strategies and future publicity campaigns. For example, it would have been useful to evaluate the impact of the game on brand recognition and sales. The trend in monthly sales figures of the *Prudence* condom before and after the game shows an initial increase but it was not sustained.

Although PSI has been able to tap different sources of funding that enabled it to implement a nation-wide social marketing program, the patchwork nature of the funding, the relatively small amounts available from each source and short funding periods makes it difficult to carry-out long-term planning. As the funds from different sources are pooled to fund the same activities, the accounting requirements also crcatc a heavy management burden.

A4. An unintended benefit of the project was improved communication between the different MOH Directorates and Divisions involved in the project. According to MOH personnel, there had previously been little exchange of information bctwccn the Directorates of Family and Mental Health, Preventive and Rural Medicine, and Pharmacy. These Directorates met on many occasions on account of the project to review the applications for regulatory approval, and greater awareness of each other's programs and activities was created among them. Weekly meetings of the Directors and the Minister have now been instituted.

B. Proiect Exuenditures

Bl. A pipeline analysis of project expenditures according to line items as used by the PSI Accounting Office is on the following page. A copy of the certified fiscal report submitted to AID in December 1993 which shows that 100% of the project funds have been expended is also included.

B2 The budget was revised in April 1993. The budget which is used by the PSI for accounting does not match the budget contained in the DIP, nor the original budget in the Cooperative Agreement.

The variances between the actual project expenditures and the budget are attributable to the following:

Overspending

1. Salaries and fringes: Once PSI Cameroon's country agreement was signed in June 1993, PSI became liable for employer taxes and social security contributions for its employees. These expenses were not budgeted for in the original budget.

Population Services International
Cameroon Child Survival Project
Financial Pipeline Analysis
01/25/95

Line It&m	Original Budget	Actual to EOP	Variance	Difference (%)	Amendment	Revised budget
US Salaries & Fringes	169,701	182,889	(13,188)	108%	13,188	182,889
Total Salaries & Fringes	169,701	182,889	(13,188)	108%	13,188	182,899
Indirect Overhead	127,663	73,601	54,062	58%	(54,062)	73,601
Travel & Transportation	24,181	45,670	(21,489)	189%	21,489	45,670
Equipment	4,000	9,124	(5,124)	228%	5,124	9,124
Packaging	93,100	200,889	(107,789)	216%	107,789	200,889
Other Direct Costs	249,062	192,840	56,222	77%	(56,222)	192,840
Subtotal for Project	667,707	705,013	(37,306)	106%	37,306	705,013
Charges Against Revenue	(167,707)	205,013	37,306	-122%	(37,306)	(205,013)
TOTAL for Project	500,000	500,000	(0)	100%	0	500,000

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CAMEROON: CHILD SURVIVAL PROJECT
co-30 AGREEMENT NO. PDC-0500-A-00-1115-00
CERTIFIED FISCAL REPORT
STATEMENT Cl' EXPENDITURES FOR THE PERIOD JANUARY - SEPTEMBER 1994

Description by line Items	Budget Amount in $	THIS REPORT Cameroon Expenses CFA	Cameroon Expenses $	PSI/Wash Disbursement for Project	CUMULATIVE FROM SEPTEMBER 15, 1991 Cameroon Expenses CFA	Cameroon Dollar Expenses	P-E I/Wash Disbursement for Project	TOTAL TO DATE	% Budget vs Total to Sate
1. Salaries & Fringes	169,701.00	152,146.00	X3.52	737.07	24,559,717.00	50,561.24	92,328.10	182,869.34	108%
2. Indirect Overhead	127,663.00			264.78	0.00	0.00	72,601.41	75,601.41	58%
3. Travel & Transportation	24,181.00	1,936,147.00	6 665.62	(3,907.01)	3,303,924.00	jO.Jli.35	15,350.49	45,689.82	189%
4. Equipment	4,000.00			(5,165.76)	2,504,295.00	5,123.69	0.00	9,123.69	228%
5. Packaging	93,100.00	16.003.Jl2.53	51.427.72	(16,664.38)	52,080,610.00	186, Xi.16	13,942.81	200,868.99	216%
C. Other Direct Costs	249,062.00	5,285,155.00	Li.347.44	(9,691.17)	44,768,962.00	163,115.76	29,724.02	292.839.76	77%
TOTAL A.I.D.	667,707.00	23.376.77C.00	75,304.30	(37,456.47)	132,217,528.00	480,066.23	224,946.83	705,013.02	106%
7. Non-Fed Expenses	167,707.00	24,400,694.50	78,556.48	(40,334.75)	51,610,384.00	179,746.95	25,266.07	205,013.02	122%
TOTAL	500,000.00	(1,021,924.50)	(3,252.18)	2,878.28	80,607,144.00	300,319.24	199,650.76	500,000.00	100%

The undersigned hereby certifies (1) that the fiscal report and any attachments have been prepared from the books and records of the contractor in accordance with the terms of this contract, and, to the best of my knowledge and belief, that they are correct, that the sum claimed under this contract is proper and due, that all the costs of contract performance (except as herewith reported in writing) have been paid or will be paid currently by the contractor when due in the ordinary course of business, that the work reflected by the costs have been performed, that the quantities and amounts involved are consistent with the requirement of this contract, that a required Contracting Officer approvals have been obtained, and (2) that appropriate refund to AID will be made promptly upon request in the event of disallowance of costs not reimburseable under the terms of this contract.

BY: _____
Title
DATE: _____

2. Travel and Transportation: The PSI Country Representative changed in June 1993, which was not originally programmed. There were therefore additional costs for travel **and** shipping of household effects that exceeded the original budget for these line items.

3. Equipment: The purchase of office equipment proved more expensive than budgeted, and shipping charges were not included in the original budget. Although the percentage variance appears high, the nominal value is relatively low.

4. Direct Costs: Packaging is the largest recurring expense in the project and was severely under-budgeted.

Underspending

Indirect Overhead: The over-budget expenditures were absorbed by reducing the indirect overhead costs charged by PSI, and where possible, charging some of the direct costs to other projects that were being implemented concurrently with the Child Survival Project.

B3. There are no apparent anomalies in the handling of project finances. Duplicates of all expense vouchers and receipts are sent to PSI/Washington every month. These documents are reviewed during PSI/Washington's annual audit. The audits and original documents are available in Washington.

B4. PSI's former system of automatically attributing 25 % of project expenditures to the PSI match, whether from revenues or other sources, created confusion. In a program with multiple project match requirements such as this one, and where match funds are generally revenues from sale of commodities and which are used for specific purposes, the automatic attribution created tracking problems. PSI changed their accounting system in late 1993, so that expenditures attributed to revenues or the match are now tracked exactly through a separate set of accounting codes.

C. Lessons Learned

i) Although social marketing involves mainly the private sector, a good working relationship needs to be established with the MOH, and its involvement and formal commitment needs to be obtained from the project design stage.

ii) The implementing agency needs to establish a presence in the administrative capital, conducive to a close working relationship with the Ministry of Health.

iii) In order to provide protection from potential litigation, the Ministry of Health needs to be formally involved in contractual agreements as a partner.

iv) Granting of government regulatory approval for pharmaceutical products or its waiver should be included in the USAID bilateral agreement where such products are funded bilaterally.

v) A regional strategy using sales agents based in each province to assist the local wholesalers in marketing and promotion is successful in increasing sales.

vi) Care should be taken in the selection of wholesale distributors and a monopoly distributor should be avoided.

vii) NGOs which have community health projects (CARE, SCF) may be associated to reach rural areas and assist in the development of a sustainable commercial distribution network.

viii) Small-scale baseline research should be carried out before a promotional campaign or activity, in order to provide a basis for planning, monitoring and evaluation of the activity.

II. PROJECT SUSTAINABILITY

A. Community Participation

As the nature of this project differs from that of typical child survival projects, this project did not involve and interact with communities and their leaders in the conventional manner, nor carry out community organization activities. The individual participates in the project by purchasing the product marketed either for re-sale or for his/her consumption. S/he purchases the product when s/he wishes to meet a perceived need. In order to ensure this participation, the project carried out consumer research to determine how the product can be best marketed, test consumer acceptance of the product and its packaging, and develop promotional messages.

The project has provided support to activities of community groups upon request. Community groups frequently requested free samples and prizes, and participation of project staff in events where condom use was promoted for health reasons. At the launch of ***Biosei*** in June 94, community NGOs developed ORS promotional activities with the assistance of UNICEF and the participation of PSI.

Wholesalers and retailers of the social marketed products may perhaps be considered as equivalent to community leaders and members involved in project activities, although wholesalers and retailers are involved in the distribution activities not usually for a desire to provide a social service but more for a profit motive.

The team did not interview any wholesalers or retailers during the evaluation, as interviews were conducted with pharmacists and condom retailers during the mid-term evaluation in December 93. Their views were solicited on project performance at the consumer level.

There are currently 25 wholesale distributors, 150 wholesalers and an estimated 8000 retailing outlets of condoms. The wholesalers include 9 NGOs, of which five are provincial drug supply centers or CAPPs (Centre d'Approvisionnement des Produits Pharmaceutiques) that supply community co-managed and co-financed health centers in the rural areas. The project also worked with all seven pharmaceutical wholesalers in the country and around 280 pharmacies for the distribution of condoms, ORS and oral contraceptives.

The development of a solid private sector commercial distribution system for condoms can last beyond a project as long as affordable product is supplied. It was noted that wholesalers

are increasingly inclined to pay cash for their condoms. The documented increases in sales indicate that the target populations have accepted the condom and lead us to believe that condom use would continue, again as long as affordable and accessible product is available. The growth in consumption continues in spite of the severe economic recession.

The small volume of sales in the social marketing of ORS and oral contraceptives does not permit these activities to remain viable as discrete activities after project funding ends. However, they can be sustained if they continue to be 'piggy-backed' on to the condom social marketing program, utilizing the same human resources, infrastructure and logistics to achieve cost-efficiency.

B. Ability and Willingness of Counternart Institutions to Sustain Activities.

Bl. The evaluation team interviewed officials from the Directorates of Family and Mental Health and Preventive and Rural Medicine of the Ministry of Health who were involved with the project (See Appendix 5). These officials are in charge of the national family planning, diarrhea1 disease control and AIDS control programs, and therefore have the responsibility of oversight and coordination of all projects active in these interventions, including this project.

The team also interviewed the health program coordinator from CARE International, one of the collaborating institutions. It was unable to interview any representative from Save the Children Federation (SCF) as it is located in the Far North Province and is not represented in Yaoundé.

There is no local NGO which is a counterpart to PSI. PSI had intended to select and work with a Cameroonian NGO partner who would eventually take over major program responsibilities. The initial counterpart, *Hospicam/Groupe Santé,* who acted as the sole wholesale distributor in the early stages of the condom social marketing program, did not perform satisfactorily and did not meet PSI's expectations. PSI then decided to diversify from a monopoly wholesale distributor to twenty-five distributors, which proved to be a successful strategy. PSI plans to help its key local staff to set up an NGO which will be its Cameroonian partner, and which will inherit the program. This plan had to be postponed until the litigation problem is resolved.

B2. The project activities form part of the national programs of the MOH as described above. Project staff also participate actively in awareness-raising campaigns organized by the MOH such as that for the Cameroon and World AIDS Days and other events. The International PVOs, CARE and SCF carry out IEC activities that promote the use of ORS, condoms, and contraceptives in the Far North and East Provinces. SCF is implementing a child survival project and an AIDS control project in the Far North Province, while CARE is implementing a primary health care project in the Far North and an AIDS control project in the East Province. They assist the program in distributing samples, and depend on the program to make the products available to meet the demand their projects help to create.

B3. The local NGO that will be created to take over the social marketing activities from PSI will be the key local institution that will sustain project activities. The MOH will continue to provide support, and other NGOs and collaborating agents will continue to collaborate and

participate to sustain social marketing activities. The local NGO will be affiliated with PSI, and become part of PSI's worldwide network. It will benefit from technical assistance, information exchange and financial oversight from PSI.

B4. The MOH personnel, in spite of a certain amount of initial cynicism, are now wholly convinced that social marketing is an effective means of promoting certain health products and practices. Ministry officials feel that the social marketing approach has been under utilized in the health programs and wish to increase the utilization of this approach to reach the target populations.

B5. PSI provided training to *Hospicam/Groupe Santé* in inventory management and basic marketing. Wholesale distributors and some wholesalers were provided training on an individual informal basis on how to handle the product, inventory management, and accounting as related to the product. Training was provided individually to pharmacists retailing the products. PSI has not provided training formally to street condom retailers, but plans to do so in the future. The project staff, when coming into contact with retailers provide a briefing on product pricing and other information.

As this is mainly a private sector program, PSI did not provided any direct training to MOH personnel. At the beginning of the project, the PSI Country Representative made a presentation on the social marketing program to some MOH officials, but which did not include those from the Directorate of Pharmacy. It would have helped to increase the MOH directors' understanding and secure support from them for the project if they had been provided with greater exposure to the social marketing approach, say through a short seminar.

B6. As explained earlier, there is no counterpart institution that can take over the program at this stage. When the local NGO partner is set up and functional, it will be able to provide the necessary human resources to continue project activities. This NGO will have the technical capability to sustain the social marketing activities, as the staff have acquired social marketing skills and experience during their tenure with PSI. The NGO can become a viable organization by winning contracts for implementing social marketing projects.

Revenues from the sale of the products can financially sustain in part the activities, although the donated sources of commodities will continue to be needed. Other material resources will also need to be donated, as the revenues are sufficient only for supporting part of the recurrent costs. Given the recent introduction of social marketing and current economic crisis, it would be unwise to undertake major prices that would be required to recover full operating costs at this time. Experience from the well-cstablishcd condom social marketing program in Bangladesh showed a significant decrease in sales when prices underwent a major increase, It is therefore unrealistic to expect the program to be completely self-sufficient and sustainable without outside inputs, particularly for commodities, for some time to come.

B9. Counterpart institutions did not make any financial commitment to sustain project activities during the design of the project.

C. Attempts to Increase Efficiency

Cl. PSI began aggressively competing bids for packaging in 1993 after determining that, with volume sales growth, packaging was its single largest expenditure. This bidding, and the ensuing price decreases, enabled PSI to save an estimated $10,000 per year, and placed it in a better position for price negotiation after the devaluation of the CFA franc in January 94.

PSI also began committing limited resources to regular travel with well-defined commercial objectives. In addition to delivering product and collecting revenues, the agents focused on assisting new distributors with the development of their sales network. PSI also invited local distributors to participate in events PSI was helping to sponsor to give the distributor greater visibility.

As the project grew larger, emphasis was placed on defining and, as needed, redefining job responsibilities. The list of all job descriptions was reviewed and amended by management staff, thus averting major gaps in the necessary components of the project activities. With the job descriptions in place, it was easier to pinpoint training needs. As such, PSI was able to obtain training at no charge to the project for both the finance manager and the warehouse/administration manager by using headquarter resources.

Clearing commodities from customs also used to be a time-consuming and costly process. When these activities were brought in-house and assigned to the administrator, he was able to cut costs in half and virtually eliminate storage fees due to delays in clearing. This saves PSI/Cameroon an estimated $500 per container or $2000 per year.

During the finance manager's training, a new voucher-based accounting system was developed. This system simplified in-country accounting and enabled PSI to more easily track different project expenditures and revenue streams. As a result, PSI is able to make reliable cash flow projections and roughly track expenditures against budget (while waiting for the certified reports from headquarters). The new system developed in Cameroon has served as a prototype for other projects opening in other countries.

A further analysis of operations and comparison with similar PSI projects in other countries led PSI/Cameroon to the realization that it was overpaying for warehouse and packaging services. The contract for these services was terminated and all activity was brought in-house. The estimated savings are $2,000/month or about $24,000 per year.

Finally, the project has worked hard to improve collaboration with other NGOs working in the same field. PSI's active participation in UNICEF's ORT promotional events provided *Biosel* with a great deal of visibility at little cost. PSI ensured that local pharmacists were advised' of the upcoming events and could meet the demand generated. In condom promotion, PSI worked with several NGOs and French Cooperation who agreed to print condom samplers for their networks. PSI supplied the assembly labor, the condoms, and coordination with the printer. In so doing, almost $10,000 worth of educational pamphlets were produced at no cost to the project.

C2. Successful attempts to increase efficiency are due to the effective identification of the problems and opportunities, and staff commitment to find a solution. Recognition is given to staff members when they realize savings for the project. Project staff are very conscious of the precarious financial future and make an effort to stretch funds. PSI's headquarters is

also very open to new ideas and very supportive when a need is well-articulated, even to the extent of providing extra resources to help solve a problem.

C3. A social marketing project differs considerably from other child survival projects. Nevertheless, there are a few lessons that may be applicable:

i) A solid administrative foundation is essential to running a cost-efficient project.

ii) The PSI/Cameroon's director's opportunities to visit other projects provided new insight into how to handle specific matters.

iii) A periodic review of project expenses will identify major cost centers. These must be analyzed to determine whether there are less expensive or more productive alternatives. This analysis should draw on the broad experience of all management staff (local as well as expatriate) as well as on headquarters resources/information. Local staff should be encouraged to identify savings opportunities.

D. Cost Recovery Attempts

D1. PSI's socially marketed products are sold rather than given away. The socially marketed price is determined to maximize volume sales and accessibility to the poor rather than to maximize cost-recovery. Nevertheless, revenues generated from the sale of products are a very important part of the budget.

Cost recovery is handled by the sales team. Pricing and credit policies are established and revised during team (sales, marketing, resident advisor) meetings. Revenue collections are carefully documented and are deposited into a revenue account opened for each product. The repayment rates of distributors in 1993 were 66% and 83% for the ***Prudence*** and ***Promesse*** condoms respectively. In 1994, repayment rates were 109% and 143 % for the two respective brands of condoms. Debt recovery rates were over LOO % as debts from 1992 and 1993 were also recovered. The improvement in repayment rates were due to better business practices, including choice of distributors that were reliable debtors.

D2. The costs recovered through sales of commodities total $270,300 over LOP (see Appendix 6 for revenues generated through sales). It should be borne in mind, however, that the program and commodities are financed through several sources, so that the percentage of project costs covered by revenues generated is over represented here. Revenues are allocated for packaging materials and labor, customs clearing charges, quality control testing, and when available, for promotional activities. Because the project's match requirement was met through the revenues generated, revenues were also occasionally used for other line items like salaries. The cost recovery most certainly generates enough money to justify the effort and funds required to implement the mechanisms.

D3. Cost recovery is an inherent part of social marketing. Nevertheless, PSI/Cameroon constantly struggles against the perception that it is a "rich" profit-making venture.

Because PSI's products are priced "free on board" Douala, there is some inequity among regions as distributors must pay for the transport of the product. Many distributors arrange

their own transport in conjunction with the purchase of other goods. This is desirable because it is the most efficient way to get goods up-country. Although raising the price to a single price delivered anywhere has been considered, it was not adopted as it would force the most efficient distributors to subsidize the others and project funds are not adequate to cover all transport costs.

D5. Lessons learned: - i) a solid, redundant system of accountability with independent checks and balances, and clear policies on who is authorized to handle funds are necessary if cost-recovery is to work properly.

ii) Staff should be paid a decent wage so that they will not be tempted to embezzle revenues. In short, a social marketing project must be run like a business.

F. Other

Sustainability-promoting activities have been discussed in Sections IIB and IID. The DIP did not contain a sustainability plan but a sustainability strategy. The project has followed the strategy in setting up a private sector condom sales network, recovering costs from product sales to pay for certain project expenses, creating brand name awareness and loyalty, conducting publicity campaigns to make the condom acceptable to Camcroonians, and training of distributors and pharmacists to sustain the activities.

III. EVALUATION TEAM

Al. The final evaluation of the project was conducted from January 5 to 20 by an external consultant, Ms Man-Ming Hung. During the evaluation, the consultant reviewed project documents, interviewed project staff, and together with PSI Country Representative, Ms Theresa Gruber-Tapsoba, met with key officials or personnel from the Ministry of I-lcalth and collaborating institutions. The consultant's scope of work is found in Appendix 7. A list of persons contacted is found in Appendix 5.

A2. The evaluation report was prepared by the consultant, Man-Ming HUNG, with input from Theresa Gruber-Tapsoba who drafted parts of Sections I. B, II. A, II .C and II. D. The consultant had editorial responsibility for the report.

BHR/PVC & SUSTAINABILITY

GUIDELINES FOR FINAL EVALUATION ASSESSMENT OF CHILD SURVIVAL PROJECTS ENDING IN 1994 (CS-VII)

The final evaluation team should address each of the following points. As far as possible, respond to each point in sequence.

I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

A1. State the objectives of the project, as outlined in the Detailed Implementation Plan.

A2. State the accomplishments of the project related to each objective.

A3. Compare project accomplishments with objectives and explain the differences. Describe any circumstances which may have aided or hindered the project in meeting these objectives.

A4. Describe unintended benefits of project activities.

A5. Attach a copy of the project's Final Evaluation Survey, and state the results for each relevant indicator (see Table 1). Please be sure the results include numerator and denominator information, as well as percentages for each indicator.

B. Project Expenditures

B1. Attach a pipeline analysis of project expenditures.

B2. Compare the budget contained in the approved DIP with the actual expenditures of the project. Were some categories of expenditures much higher or lower than originally planned? Please explain.

B3. Were project finances properly handled?

B4. Were there lessons learned. regarding project expenditures that might be helpful to other PVO projects, or relevant to USAID's support strategy

B. Ability and Willingness Of Counterpart Institutions to Sustain Activities

B1. Please identify persons interviewed and indicate their organization and relationship to the child survival project.

B2. . What linkages exist between the child survival project and the activities of key health development agencies (local/municipal/district/provincial/state level)?

B3. What are the key local institutions the PVO expects to take part in sustaining project activities?

B4. Which child survival project activities do MOH personnel and other staff in key local institutions (including counterpart organizations) perceive as being effective?

B5. What did the PVO do to build skills of local MOH personnel or staff of key counterpart NGOs? Did they teach them to train CHWs, or manage child survival activities once USAID funding terminates?

B6. What is the current ability of the MOH or other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends?

B7. Are there any project activities that counterpart organizations perceive as effective?

B8. How have major project responsibilities and control been phased over to local institutions? If this has not been done, what are the plan and schedule?

09. Did any counterpart institutions (MOH, development agencies, local NGOs, etc.), during the design of the project (proposal or DIP), make a financial commitment to sustain project benefits? If so, have these commitments been kept?

B10. What are the reasons given for the success or failure of the counterpart institutions to keep their commitment?

B11. Identify in-country agencies which worked with the PVO on the design, implementation, or analysis of the midterm evaluation and this final evaluation.

E3. Did the revenues contribute to meeting the cost of health activities? What percentage of project costs did income generation cover?

E4. Are there any lessons to be learned regarding household income generation that might be applicable to other PVO child survival projects or to USAID's support strategy?

F. Other

FI. Describe what sustainability-promoting activities were actually carried out by the PVO over the lifetime of the project.

F2. Indicate which aspects of the sustainability plan the PVO implemented satisfactorily, and which steps were never initiated. Identify any activities which were unplanned, but formed an important aspect of the PVOs sustainability effort.

F3. What qualitative data does the PVO have indicating a change in the sustainability potential of project benefits?

III. EVALUATION TEAM

AI. Identify by names, titles and institutional affiliations all members of the final evaluation team.

A2. Identify the author of the evaluation report.

Condom Distribution by Month and Fiscal Year

Appendix 2

Month	FY 91		FY 92			FY 93				FY 94				Total FY 92-94
			Prudence		Promesse	Prudence		Promesse		Prudence		Promesse		
	Sales	Samples	Sales	Samples	Sales	Sales	Samples	Sales	Samples	Sales	Samples	Sales	ples	
act	192,000	13,369	240,000	0		342,720	29,760	36,000		595,200	10,969	21,600	240	
Nov	240,000	2,112	384,000	0		449,280	68,160	28,320		340,800	16,224	12,000	1,797	
Dec	192,000	5,832	576,000	5,287		656,640	2,880	21,120		408,000	13,252	19,200	840	
Jan	240,000	840	432,000	0		537,600	10,304	14,880	7,401	496,320	38,270	24,000	480	
Feb	240,000	2,310	336,000	48,000		396,480	24,666	16,800	720	672,000	6,466	9,600	1,200	
Mar	96,000	504	432,000	0		430,080	4,176	3,600	720	816,000	13,896	19,200	7,680	
Apr	240,000	0	285.120	3,840		594,240	11,151	9,840	1,440	1,012,800	52,564	30,720	1,440	
May	144,000	1,187	328,320	3,840		367,680	3 1,807	14,400	19,680	499,200	23,978	16,800	720	
June	240,000	1,556	422,400	4,800	9,600	377,280	12,807	20,880	2,880	249.600	11,520	14,400	1,440	
July	96,000	0	432,000	8,640	14,400	421,440	59,321	29,280	3,360	91,200	0	0	240	
Aug	240,000	391	432,000	17,280	7,200	210,240	9,366	12,000	240	0	0	0	0	
Sep	240,000	4,321	336,000	40,320	22,800	409,920	11,128	19,680	1,200	672,000	14,538	0	0	
Total	2,400,000	32,422	4,635,840	132,007	54,000	5,193,600	275,526	226,800	37,641	5,853,120	201,677	167,520	16,077	
Total for FY	2.432.422		4.82 1,847			5,733,567				6.238.394				16,793,808

Total Promesse distribu 502,038
% Total condoms distri 3.0%

Total Samples 662,928
% Total condoms distri 4%
Total Sales 16,130,880
% Total condoms distri 96%

Population of Project Area

Appendix 3

City	1987	1988	1989	1990	1991	1992	1993	1994
Original Project area								
Douala	809,852	857,800	901,400	947,300	994,500	1,043,300	1,094,100	1,147,900
Yaounde	649,252	698,900	744,800	793,600	844,800	899.300	955,300	1,013,800
Garoua	142,172	150,404	159,112	168,325	178,071	188,381	199,288	210,827
Maroua	123,447	130,595	138,156	146,155	154,618	163,570	173,041	183,060
Bamenda	110,692	117,101	123,881	131,054	138,642	146,669	155,161	164,145
Bafoussam	112.919	119,457	126,374	133,691	141,431	149,620	158,283	167,448
Nkongsamba	85,564	90,518	95,759	101,304	107,169	113,374	119,939	126,883
Ngaoundere	78,211	82,739	87,530	92,598	97,959	103,631	109,632	115,979
Kumba	70,281	74,350	78,655	83,209	88,027	93,124	98,516	104,220
Additional area covered								
Limbe	44,611	47,194	49,927	52,817	55,875	59,111	62,533	66,154
Bertoua	43,600	46,124	48,795	51,620	54,609	57.77 1	61,116	64,655
Ebolowa	34,887	36,907	39,044	4 1,305	43,696	46,226	48,903	51,734
Buea	33,017	34,929	36,951	39,091	41,354	43,748	46,28 1	48,961
Kribi	21,531	22,778	24,096	25,492	26,968	28,529	30,181	31,928
Sangmelima	23,335	24,686	26.115	27,628	29,227	30,919	32,710	34,604
Mokolo	17,785	18,815	19.904	21,057	22,276	23,566	24.930	26,373
Abong Mbang	10,377	10,978	11,613	12,286	12.997	13,750	14,546	15,388
Total Population	2,411,533	2,564,275	2.712.113~	2,868,530	3,032,219	3,204,589	3,384,459	3,574,058
Women 1549 years	547,418	582,090	615.650	651,156	688,314	727,442	768,272	811,311
Children < 5 years	424,430	451,312	477,332	504,861	533,671	564,008	595,665	629,034

'*Population growth rate of cities other than Yaounde and Douala estimated at 5.79%

Source of population figures and projections: 1987 Census - Demo 87 Volume II Résultats Bruts, Volume III Analyse Préliminaire.

Direction Nationaledu deuxième Receusemeut Général de la Population et de l'Habitat

PSI/CAMEROON, BP. 4989 ***Douala, BP. 14025 Yaounde***

PRUDENCE ***PLUS SALES AND PER CAPITA*** CONSUMPTION BY ***PROVINCE***

PRUDENCE PLUS SALES BY PROVINCE (Revised 30 January 1995)

Year	Littoral	Southwest	Central	South	East	Northwest	West	Adamnoua	North	Far North	SALES PPLUS
1989 TOTAL	239.936	96,000	370.752	0	0	0	19.200	0	0	0	725,868
1990 TOTAL	438.880	0	953,952	0	0	105,600	330.240	0	99.840	19200	1.967.712
1991 TOTAL	768,000	96,000	1,248,000	0	0	480,000	288,000	4 8 . 0	0	48,000	2,976,000
1992 TOTAL	1.334.400	192.003	1,443,840	158.400	120,000	350,400	949,440	48,000	120.000	168,000	4,884,480
1993 TOTAL	1,658,880	216,000	1,595,520	145,920	X3.600	336,000	936,000	24,000	96,000	47,040	5,088,960
1994 TOTAL	2.01 I.200	283.200	1,698,240	189.120	264,000	432,000	1,632,000	72,000	96,000	24,000	6.701.760

POPULATION BY PROVINCE. extrapolated at growth rats of 2.9% per 1987 Census

Year	Littoral	southwest	Central	South	East	Northwest	west	Adamaoua	North	Far North	TOTAL POPULATION
1997 CENSUS	I,352,833	838,042	1,651,600	373.798	517.193	1.237.3-W	1,339,791	495,185	832.163	1,855,695	10.493.65s
1988	1,392,065	962,345	1699.496	384,638	532.197	1,273,231	1.37e.643	509,545	856,296	1.W9.510	10.797.971
1989	1,432,435	887,353	I-748.782	395,793	547.630	1.310.155	1,418,626	524,322	881,130	1,964,886	11.111.112
1990	1.473.976	913.086	1.799.496	407.271	563,512	1,348,149	1,459,766	539.528	906.683	2,021,868	11,433,334
1991	1.516.721	939,566	1.851.682	419,881	579.654	1,387,246	1,502,099	555,174	932,977	2,080,502	11.764.901
1992	1,560,706	966.813	1.9c8.381	431.235	596,669	1.427.476	1,545,660	371,274	960.033	2.140.836	12,106,083
1993	1605,966	994.851	1.960.637	443.741	613.973	1.468.673	1.590.48-I	387.841	987,074	2.202.921	12,457,160
1994	1.652.53s	1.023.702	2.017.495	456,689	631.778	1,511,470	1,636,608	604,888	1,016,523	2.266.805	12,818,417
1995	1.700.463	1,053,389	2,076,003	469.851	650,100	1,555,302	1.6W.070	622.430	1.046002	2,332,543	13,190,151

PER CAPITA CONDOM CONSULIPTION (Prudence Sales Only)

Year	Littoral	Southwest	Central	South	East	Northwest	West	Adamaoua	North	Far North	CONSULIPTION PPLUS (Sales Only)
1989 TOTAL	0.17	0.11	0.2 1	0.00	0.00	0.00	001	0.00	0 00	0.00	0.07
1990 TOTAL	0.31	0.00	0.53	0.00	0.00	0.08	0.23	O W	0 II	0 01	0.17
1991 TOTAL	0.51	0.10	0.67	0.00	0.00	0.35	0.19	0.09	0.00	0.02	0.25
1992 TOTAL	0.85	0 20	0.76	0.37	0 20	0.25	0.61	009	0 12	0.08	0.40
1993 TOTAL	1.03	0 22	0.81	0.33	0.05	023	0.59	004	0.10	0.02	0.41
19% TOTAL	1.22	0.26	0.84	0.41	0.42	0.29	1.00	0.12	009	0.01	0 . 5 2

List of Persons Interviewed

Population Services International

Theresa GRUBER-TAPSOBA
Country Representative

Moussa ABBO
Commercial Director

Marie Louise BALENG
Marketing Manager

Foyet LEGER
Management Information System Manager

Ministry of Health
Dr. Philippe TSITSOL-MEKE
Director, Family and Mental Health

Dr. Chouaïbou NCHARRE
Deputy Director, Preventive and Rural Medicine

Dr. Colonel MPOUDI NGOLE
Chief, AIDS Control Unit

Paul DELON
IEC Officer, AIDS Control Unit

Dr. KAMWA
Director, Hospital Medicine

Me. Adalbert NGUIDJO-NYAM
Legal Counsel

Cooperating Agencies

Alexis BOUPDA KUATE
Resident Coordinator, AIDSCAP Project

George VISHIO MINANG
Resident Advisor, SEATS Project

Eleonore FOSS0 SEUMO
CARE International/Cameroon

PSI-CAMEROUN
BP. 4889 DOUALA, BP. 14025 YAOUNDE

ETAT DE REVENUS ISSUS DES VENTES DES PRODUITS (OCT. 91 - SEPT. 1994)

MOIS ET ANNEE	PRODUITS (Compte Bancaire)			
	PRUDENCE (01018763)	PROMESSE (01019571)	BIOSEL (1010629)	NOVELLE (1010610)
OCTOBRE 1991	0			
NOVEMBRE 1991	0			
DECEMBRE 1991	750,000			
JANVIER 1992	84,000			
FEVRIER 1992	0			
MARS 1992	2.300.000			
AVRIL 1992	1,076,900			
MAI 1992	926,000			
JUIN 1992	2.318.320			
JUILLET 1992	1,183,450			
AOUT 1992	2,719,656			
SEPTEMBRE 1992	2 577,315	329,000		
TOTAL FY92	13.935.641	329,000	0	0
TOTAL ($) @250	$55.743	$1,316	$0	$0
OCTOBRE 1992	683,500	25000		
NOVEMBRE 1992	1,105,000	470,000		
OECEMBRE 1992	2,470,440	188,000		
JANVIER 1993	1.656.500	705.m		
FEVRIER 1993	2,313,800	94,000		
MARS 1993	2,508,600	517,coo		
AVRIL 1993	1.969.615	152,400		
MAI 1993	1.395.460	188.000		
JUIN 1993	1,500,275	251,500		
JUILLET 1993	2,121,325	564,000		
AOUT 1993	984,360	547,900		
SEPTEMBRE 1993	28204.575	489,800		
TOTAL FY93	20,813,470	4,192,600	0	0
TOTAL ($) @250	$83,254	$16,770	SO	SO
OCTOBRE 1993	3,662,000	557,000		
NOVEMBRE 1993	3,730.950	63,300		
DECEMBRE 1993	3,133,951	773,500		
JANVIER 1994 (DEV)	3,150,845	520,300		
FEVRIER 1994	4,397,565	351,900		
MARS 1994	7,054,420	51,400		
AVRIL 1994	4,252,425	423,000		
MAI 1994	3,773,370	615,500		
	A/C 1010645	A/C 1010637		
JUIN 1994	2,445,950	564,000		
JUILLET 1994	1,746,570	451,200		
AOUT 1994	1,149,600	332,000	540,000	210,000
SEPTEMBRE 1994	3,005,690	679,576	0	0
TOTAL FY 94	41,503,336	5,382,676	540,000	210,000
TOTAL($)@250; 545	$98,945	$12,894	$991	$385
TOTAL CS PROJECT	76.252.447	9,904,276	540,000	210,000
TOTAL FY92-94($)	5237,942	$30.981	$991	$385

Description of Work

Man-Ming Hung
Cameroon, Child Survival VII
Final Evaluation

The intended output of this consultancy is a final written report following the attached "BHR/PVC Guidelines for Final Evaluation & Sustainability Assessment of Child Survival Projects Ending in 1994 (CS-VII)". To achieve this, the following tasks will be undertaken in collaboration with the resident advisor and local staff:

1. Review all project documentation including sales statistics.

2. Conduct interviews with key project personnel, Ministry of Health Personnel, and PSI's NGO partners.

3. Conduct interviews with private sector partners, particularly pharmacist and non-pharmacist distributors.

4. Review the issue of sustainability and, as appropriate, conduct interviews with appropriate agencies.

5. Review PSI/Washington's pipeline analysis of budget expenditures.

6. Synthesize findings and assume principle responsibility for writing the final evaluation report.